

per 100 000 in the general population. Recent studies in molecular genetics have shown that multiple BCC are caused by mutations in the PTCH (Patched) gene found on chromosome 9q. Additionally, patients with Gorlin-Goltz syndrome tend to develop more benign skin lesions regrouped under the denominations of basocellular nevi or basaloid follicular hamartomas.

Observation:

Here we present the case of a 4 year-old boy presenting with an agenesis of corpus callosum at birth and who has subsequently developed multiple dermoid cysts of the face, macrocephalia, congenital convergent strabism and an important developmental delay. A genetic cause has been discussed and following multiple investigations, a mutation in the PTCH gene has been demonstrated, thus confirming the diagnosis of Gorlin-Goltz syndrome. The patient has subsequently, since 2011, developed skin lesions on the whole body. Assuming the diagnosis of Gorlin-Goltz syndrome, we suspected the occurrence of BCCs. Excisional biopsies performed on several body areas showed basaloid tumoral processes without all of the classical aspects of BCC (absence of palisading or peritumoral retractions). We finally diagnosed these lesions as basocellular nevi, a histopathological entity of better prognosis than classical BCC. The patient has therefore undergone superficial excisions of the different lesions instead of classical surgical removals of the tumors.

Discussion:

Gorlin-Goltz syndrome is classically associated with the rapid and progressive occurrence of multiple BCC throughout life, with potential impacts on the quality of life and overall survival of the patients. Other clinical and histopathological entities such as basocellular nevi or basaloid follicular hamartomas can also be found in these patients. These lesions tend to be less extensive than true BCC and can be managed without need for complete surgical excisions especially in young patients.

P79

Souvenir de vacances

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We describe a case of a 67-year old woman who develops three painful subcutaneous nodules with surrounding erythema and a central hemorrhagic crust localized on the left wrist and the upper back after having spent her holidays in Mexico. Soon after the first visit at our clinic she was able to extract a larva, allowing to diagnose a cutaneous myiasis from furuncular subtype.

There is a worldwide distribution of myiasis, but with more species and abundance in lower socioeconomic regions of tropical and subtropical regions. With a higher number of returning travelers from these regions we are more often confronted with tropical infections or parasites implicating knowledge about differential diagnosis, diagnostic and therapeutic approaches.

P80

Mycobacterium marinum infection treated without discontinuation of anti-TNF agent in a Crohn's disease patient: a case report

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Introduction: We report a case of *Mycobacterium marinum* in Crohn's patient on adalimumab, who was treated with antibiotics without interruption of the anti-TNF agent.

Observation: A 44-year-old man who had received adalimumab for Crohn's disease over the previous 5 years, presented to our clinic with a history of 2 months asymptomatic lesions on the right arm. He developed a progressive inflammatory nodular infiltrate on his right wrist followed by the onset of lesion over the forearm and arm with a sporotrichoid pattern. A non painful swollen right axillary node was noted. He owns a home fish tank that he used to clean regularly with his right hand. Skin biopsy was taken and histology revealed a moderate lympho-histiocytic and granulomatous infiltrate. Even with the negative specific coloration, the suspicion of *M. marinum* infection was high, and we decided to treat the patient without stopping the anti-TNF. An antibiotherapy with rifampicine and clarithromycin was installed. Meanwhile, the infection with *M. marinum* was confirmed by bacterial culture. A complete remission was noted after 26 weeks of antibiotherapy, with no relapse at the third month of follow-up.

Discussion: The anti-TNF therapy was a revolution in the treatment of chronic inflammatory diseases since its introduction over the decade. The increased risk of opportunistic infections, including atypical mycobacterial infections, has been reported with the use of anti-TNF. *M. marinum* is a free-living mycobacterium subspecies whose natural habitat is water. Exposure to fresh or salt water fish associated with injuries can cause *M. marinum* infection. There is no consensus for the therapy, but combination of rifampicin with clarithromycin + etambutol seems to resolve skin lesions and to induce total remission. A discontinuation of anti-TNF is recommended, but not mandatory. Among 17 cases of *M. marinum* cutaneous infections reported in the literature, the anti-TNF was held while the patients were receiving the anti-mycobacterial treatment. In 3 cases, an anti-TNF was reintroduced once the infection was completely treated. In 3 other patients, it was resumed while they were still on antibiotics.

Conclusion: In our case, a Crohn's disease patient was treated and healed from a *M. marinum* infection, without interruption of adalimumab therapy. This may lead to reconsider the necessity of discontinuing anti-TNF agents in the case of a benign course of the infectious disease.